Health, Welfare Public Service

300 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-011456
STATE FILE NUMBER

MAR 17 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 2185

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Baptist Hosp — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri
b. COUNTY
c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 4366 Maryland Av. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First Mary — Middle A. — Last Tierney

4. DATE OF DEATH: Month 3 — Day 1 — Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-20-1897

9. AGE (In years last birthday): 61 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country): St. Louis Mo

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME: James A. Tierney

13b. MOTHER'S MAIDEN NAME: Ellen T. Shea

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 492-01-3222

17. INFORMANT: Aloysius Tierney — Address: 4366 Maryland Av.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gangrene of ileum and peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Intestinal obstruction.
DUE TO (c) Calcified fibroid
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): acute glomerular nephritis . 214X

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION — COUNTY — STATE

21. I attended the deceased from 2/7/59 to 3/1/59 and last saw her/him alive on 2/28/59
Death occurred at 4:55 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Hugo F. Bergmann MD

22b. ADDRESS: 3220 Washington

22c. DATE SIGNED: 3/2/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 3-4-1959

23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery

23d. LOCATION (City, town, or county) (State): St. Louis Mo.

24. FUNERAL DIRECTOR — ADDRESS: Cullinane Bros. 3320 N. Kingshighway

25. DATE RECD. BY LOCAL REG.: MAR 3 '59

26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. ..... working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed J. Wm Bentley

Licensed Embalmer No. 365

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.